AND PLAN	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(XS) WITE	TIPLE CONSTRUCTION	OMB NO. 093
		IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE SURVE
		445415	B. WING		1
NAME OF P	ROVIDER OR SUPPLIER		<del></del>		10/21/201
NHC HEA	LTHCARE, FARRA	GUT	1	REET ADDRESS, CITY, STATE, ZIP CO. 120 CAVETT HILL LANE	DE
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES		KNOXVILLE, TN 37922	
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F 272 SS=D	483.20(b)(1) COMI ASSESSMENTS	PREHENSIVE	F 272	, vestdeut	#9 & #14 11/11
1	The facility many			comprehensive as	sissman+
		nduct initially and periodically accurate, standardized		ard not include	periodial
	Chipardoinic Sees	SMENT Of Anob regide-4		Side rail assiss	nente al
<u> </u>	functional capacity.	or cach residents		current side rail	assess
L	A facility must			ment was provided Resident #9 & #16	don
í	A facility must make	a comprehensive		by ; , RN.	t on 10-24-1
1.55	-AIMALIE MODESSI HE	I INSCRIPTANT /DAN		, «	· .
		ssessment must include at		B. Allin hous	se residents
			1	were reviewed on	11_0_11
100	ustomary routine;	mographic information;		utilizing the sid	le reil
_	cognitive patterns;			assessment form b	y : _
10	ommunication:	1	ŀ	, RN. No ad	verse
V	ision:			outcomes were rep	orted for
I M	lood and behavior p	patterns;	1	use of side rails	in the
1 1- 1	SVUITUSOCIAI WALLA	Do:	- 1	facility. The nur was inserviced on	sing staff
		and structural problems;	1	& 11-3-2011 regar	dina
Di	sease diagnosis an	d health conditions;		comprehensive ass	OCCHOR+ 4
	rica and number	status;		side rail assessm	ents by
1 OK	in conditions:	And have republished a		DON . Con	tent of
Me	tivity pursuit; edications;			inservice included	d dida
Sp	ecial treatments an	d procedures:		rail assessment or	a adminute
Ula	charde poteutal.	000		orders ;	- : Follyand but
Do	cumentation of sur	nmary information regarding		assissment with co	us, quarterly
1	HAMINDING GOODSKI	THUT DADDONAL ALL		THE PROPERTY OF THE PARTY OF TH	1
1	as inggered by the a Set (MDS); and	completion of the Minimum	}	C. Nursing sta	off was
Dog	cumentation of parti	clpation in assessment.		inserviced by	Dhn
	or petiti	reposition assessment,		on 11-1-2011 & 11-	3_11
				through sharing of	SUCTOR
1		1	1	results and plan o	f correction
	,	1		regarding process	changoe
	/ /			for side rail asse and use of side ra	ssmente
		UPPLIER REPRESENTATIVE'S SIGNATUR	1	and hed of side	A

Any delicientry statement ending with an asterisk (\*) denotes a deliciency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/08/2011 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445415 NAME OF PROVIDER OR SUPPLIER 10/21/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, FARRAGUT 120 CAVETT HILL LANE KNOXVILLE, TN 37922 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX (XS) TAG DATE DEFICIENCY) F 272 Continued From page 1 Quality assurance will F 272 audit and monitor every 3 months X 2 for compliance This REQUIREMENT is not met as evidenced and PRN for use of resident by: Based on medical record review, observation, side rail assessment form review of facility policy, and interview, the facility on admission, quarterly, failed to perform periodic assessments for the cos, and annually to comply use of side rails for two (#9, #14) of three with F-272 guidelines. residents reviewed from twenty-eight residents using siderails. The findings included: Resident # 9 was readmitted to the facility on September 21, 2011, with diagnoses including status post Left Total Hip Arthroplasty, status post Revision of Left Total Hip Arthroplasty, Atrial Fibrillation, Cournadin Therapy, and Sick Sinus Syndrome with Permanent Pacemaker. Review of the Minimum Data Set (MDS) dated September 28, 2011, revealed the resident required extensive assistance with bed mobility, transfers, and moderate to extensive assistance with activities of daily living. Medical record review of Physician's orders dated September 21, 2011-December 20, 2011, revealed "...Side rail use is optional per patient preference. This is not a restraint..." Continued medical record review revealed no documentation of a side rail assessment. Review of facility policy "Proper Use of Side Rails" revealed, "...3. An assessment will be

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made to determine the resident's symptoms or reason for using side rails. When used for

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/08/2011 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445415 NAME OF PROVIDER OR SUPPLIER 10/21/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, FARRAGUT 120 CAVETT HILL LANE KNOXVILLE, TN 37922 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 272 | Continued From page 2 mobility or transfer, an assessment will include a F 272 review of the resident's bed mobility and ability to change positions, transfer to and from bed or chair, and to stand and toilet ... " Observation of the resident on October 18, 2011, at 7:30 a.m., and October 20, 2011, at 7:30 a.m., revealed elevated bilateral upper half side rails, when the resident was in bed. Continued observation on October 18, 2011, at 10:30 a.m., revealed the rails were lowered when the resident was not in bed. Interview with the resident on October 20, 2011, at 3:50 p.m., at the second floor nurse's station, revealed the resident used the rails as an assistive device. "...I use them to help me move in the bed at night, they let them down during the day..." Interview with the Director of Nursing, on October 20, 2011, at 1:50 p.m., in the conference room, revealed "...On admission, the admission nurse does an initial side rail assessment; the results are entered into the I-MAR (electronic medical documentation) and printed as a physician's order. There is no assessment form retained in the chart. Assessments are done on admission, readmission, and at a significant change of the

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resident. There are no routine reassessments..."

Interview with the Charge Nurse Registered Nurse (RN #1) on October 20, 2011, at 3:50 p.m., at the second floor nurses station, confirmed there was no documentation the side rail assessments had been completed.

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Facility ID: TN4718

If continuation sheet Page 3 of 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF	PROVIDER OR SUPPLIER	445415	B. WING			
	ALTHCARE, FARRAG	SUT	s	TREET ADDRESS, CITY, STATI 120 CAVETT HILL LANE	E, ZIP CODE	1/2011
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		KNOXVILLE, TN 37922		
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F 272	Continued From pa	ge 3	F 272			
	MINION ZU, ZULI MIN	dmitted to the facility on h diagnoses including Multiple on, Anxiety, Agitation, and				
	on the staff for all ac	10 10 10 10 10 10 10 10 10 10 10 10 10 1	2 4	5		
],	resident was "totally	w of the Weekly Nursing October 2011, revealed the dependent" on the staff for lying position, turning side to while in bed."				
1	Medical record review documentation of ass ails.	revealed no curent essment for the use of side				
	Observation on Octobevealed the resident is possible to the possible rails in the contract of	er 20, 2011, at 7:25 a.m., n bed with both of the raised position.				
8: skc rai ex int	03 a.m., revealed the de ralls in the raised pils "could be restrictive tend or straighten the erview confirmed the the use of side rails."	facility failed to assess				
38=D CC	3.20(d), 483.20(k)(1) MPREHENSIVE CA	RE PLANS	F 279		(11/	11/11
to c	acility must use the re develop, review and r	esuits of the assessment				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/08/2011 FORM APPROVED

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL(	ILTIPLE CONSTR	UCTION	(X3) DATE	SURVEY
		110000	Sec. 1			COMP	ETED
NAME OF	PROVIDER OR SUPPLIER	445415	B. WING	3		401	
	EALTHCARE, FARRAG	SUT	s	120 CAVETT F		10// E	21/2011
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		KNOXVILLE,	TN 37922		
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F 279	Continued From pa	ae 4	_				
	The facility must de plan for each reside objectives and times medical, nursing, ar needs that are ident assessment.  The care plan must to be furnished to att highest practicable p psychosocial well-be §483.25; and any selbe required under §4 due to the resident's	velop a comprehensive care int that includes measurable tables to meet a resident's id mental and psychosocial ified in the comprehensive describe the services that are	F 27	hensivinclud The ca 10-24- side r device by: #14 co plan d antips The ca: on 10- of ant: monitor	Resident #9 Te care plan Te use of side Te plan was 11 to include The ails as an appear patient The RN. Resident include The plan was 24-11 to include The plan was The plan w	did not derails. updated le use or ssistive reques de use care de use cation. updated lude use rugs wit	on <b>E</b>
fa fa or result (# ps in The Se	Based on medical recacility policy review, a acility policy review, a ailed to develop a car f side rails for one (#eviewed of twenty-eignis; and failed to develop a car of the psychoa at 4) of four residents sychotropic medication Stage 2.  The findings included:  The sident # 9 was reading thember 21, 2011, with a sident was reading thember was reading thember 21, 2011, with a sident was reading thember 21, 2011, with a sident was reading thember 21, 2011, with a sident was reading thember was reading thember was reading the sident was re	is not met as evidenced cord review, observation, and interview, the facility e plan to address the use 9) of three residents ht residents using side elop a care plan to address ctive drug Seroquel for one reviewed for the use of his of thirty-three residents  mitted to the facility on ith diagnoses including p Arthroplasty, status post	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	include assessme care place any lice adverse from omito the coresident drugs careviewed nursing to be inadverse from omito trugs to	starting on idents care use of side ent outcome an coordinatensed nurse. Outcomes we ission of side ent outcomes were plans were plans were plans were plans were compliance outcomes were ssion of ant the care plans the care plans the care plans were specially the care plans were plans were plans were plans were plans the care plans staff was the care plans staff was staff w	plans virtuals plans virtuals por the ors or No re found antipsy results on no re found so no re found answer.	der I chot:

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445415 B. WING. NAME OF PROVIDER OR SUPPLIER 10/21/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, FARRAGUT 120 CAVETT HILL LANE KNOXVILLE, TN 37922 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE PREFIX DEFICIENCY F 279 Continued From page 5 F 279 inserviced by the DoN Revision of Left Total Hip Arthroplasty, Atrial Fibrillation, Coumadin Therapy, and Sick Sinus 11-1-2011 & 11-3-2011 Syndrome with Permanent Pacemaker. regarding updating the care plans with use of side rails Medical record review of Physician's orders dated if needed and use of September 21, 2011-December 20, 2011, antipsychotic drugs. revealed "...Side rail use is optional per patient preference. This is not a restraint... Nursing staff was inserviced by Medical record review of the Care Plan dated DON dn 11-1-2011 & 11-3-11 through October 11, 2011, revealed no documentation of sharing of survey results the use of side rails as an assistive device. and the plan of correction Observation of the resident on October 18, 2011, regarding updating compreat 7:30 a.m., and October 20, 2011, at 7:30 a.m., hensive care plans as necessary. revealed elevated bilateral upper half side rails, when the resident was in the bed. Continued D. Quality assurance will observation on October 18, 2011, at 10:30 a.m., audit and monitor every 3 revealed the rails were lowered when the resident months X 2 and PRN for was not in the bed. compliance to ensure that: if a side rails if needed and Review of facility policy "Proper Use of Side antipsychotic drugs are Rails" revealed, "...4. The use of side rails as an assistive device will be addressed in the resident care planned to comply with care plan..." F-279 guidelines. Interview with the resident on October 20, 2011, at 3:50 p.m., at the second floor nurse's station revealed the resident used the rails as an assistive device "...1 use them to help me move in the bed at night, they let them down during the day..."

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the resident's Care Plan.

Interview with Registered Nurse (RN #1) on October 20, 2011, at 4:00 p.m., in the second floor nurses station, confirmed the use of side rails as an assistive device was not addressed on

Evant ID: JIEC11

Facility ID: TN4716

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 11/08/2011 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING 445415 B. WING NAME OF PROVIDER OR SUPPLIER 10/21/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, FARRAGUT 120 CAVETT HILL LANE KNOXVILLE, TN 37922 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LOC IDENTIFYING INFORMATION) TAG PREFIX (X6) COMPLETION DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 279 Continued From page 6 F 279 Resident #14 was admitted to the facility on March 28, 2001, with diagnoses including Multiple Sclerosis, Depression, Anxiety, Agitation, and Hallucinations. Observation on October 20, 2011, at 10:35 a.m., revealed the resident pleasant and in the reclining Geri-chair in the room. Medical record review revealed a physician's order written September 29, 2011, for Seroquel 12.5 milligrams (an anti-psychotic) every evening. Review of the medication administration record revealed the medication was administered as ordered. Review of the current care plan revealed no documentation of the use of the drug Seroquel, Interview at the 2nd floor nurses' station with Registered Nurse (RN) #1 on October 20, 2011, at 9:51 a.m., confirmed the facility failed to develop a care plan for the use of the psychoactive drug Seroquel. F 334 483.25(n) INFLUENZA AND PNEUMOCOCCAL F 334 SS=D **IMMUNIZATIONS** 11/11/11 The facility must develop policies and procedures that ensure that -(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the

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Event ID: JIEC11

Facility ID: TN4716

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	ALTHCARE, FARRA	€UT	s	TREET ADDRESS, CITY, STATE, ZIP CO 120 CAVETT HILL LANE	10/21/2011 DE	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	KNOXVILLE, TN 37922  PROVIDERS PLAN OF COP	RECTION   not	
146	REGULATORY OR I	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CHAIRE	
i i i i i i i i i i i i i i i i i i i	annually, unless the contraindicated or to immunized during to immunized during to immunize the resident or representative has a liminual to the resident's not documentation that following:  (A) That the resident's not documentation; and potentiation; and potentiation; and potentiation that the resident immunization; and the properties of the facility must develop the facility of the facility contraindical ready been immunization; and the munization; and the munization; and the facility mere facility and the facility mere facility	offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period; the resident's legal the opportunity to refuse hedical record includes indicates, at a minimum, the hit or resident's legal provided education regarding ential side effects of influenza hit either received the hon or did not receive the hon due to medical refusal.  elop policies and procedures preumococcal resident, or the resident's receives education regarding hital side effects of the fered a pneumococcal the Immunization is fed or the resident has resident's legal opportunity to refuse lical record includes icated, at a minimum, the	I I I I I I I I I I I I I I I I I I I	and was monitored out the 48 hours immunization by no with the omission temperature on 7p-During this monitor no negative outcomfound.  B. As of 11-7-residents who recefu immunization if facility will have temperature monitorshift x 48 hours p No adverse outcome found or reported administration of zation and no febrication in the staff was inserviced for this inclusion of the coord. This inclusion is included, administration decord and post immunitation in the coord and p	through- post post post post post post post post	

CENTE	RS FOR MEDICAR	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FOR	D: 11/08/201 M APPROVE
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		445415	B. WING_			•
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NHC HE	ALTHCARE, FARRA	GUT	1	REET ADDRESS, CITY, STATE, ZIP COD 20 CAVETT HILL LANE (NOXVILLE, TN 37922	É	
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	(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.		F 334	DEFICIENCY		
the control of the co	Based on medical rollicy, and interview ne medical record in esident was provide enefit and potential nunization for one temperature folloasident #56 was adeptember 13, 2011, ehabilitation after Kredical record review	mitted to the facility on				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 446415 NAME OF PROVIDER OR SUPPLIER 10/21/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NHC HEALTHCARE, FARRAGUT 120 CAVETT HILL LANE KNOXVILLE, TN 37822 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) Continued From page 9 F 334 20, 2011, at 12:20 p.m. Medical record review revealed no documentation of education regarding the benefit and potential side effects of the influenza immunization. Interview with the Infection Control Officer and the Director of Nursing in the second floor activity room on October 21, 2011, at 8:51 a.m., confirmed the facility failed to document education regarding the immunization. Review of the facility policy (un-numbered) revised October 1, 2008, titled Infection Control Manual, revealed, "... The following 48 hours after vaccination Nursing is responsible for checking patient temperature every shift." (The facility nursing shifts are 12 hours from 7-7.) Review of the medical record revealed no documentation the resident's temperature was obtained after the injection until the 7AM shift on October 21, 2011. Interview with the Infection Control Officer and the Director of Nursing in the second floor activity room on October 21, 2011, at 8:51 a.m., confirmed the facility failed to follow the facility policy to obtain temperature on residents after the immunization. 483.60(b), (d), (e) DRUG RECORDS, F 431 LABELISTORE DRUGS & BIOLOGICALS F 431 SS=D 11/11/11 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an

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accurate reconciliation; and determines that drug

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Facility ID; TN4716

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			A. BUILD	ING		COMPLET	ED
	·	445415	B. WING				
	PROVIDER OR SUPPLIER		8	TREET ADDRESS O	ITY, STATE, ZIP CODE	10/21/	2011
	ALTHCARE, FARRAC		1	120 CAVETT HILL KNOXVILLE, TN	LANE		
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F 431	Continued From pa	nre 10					
	records are in order	r and that an account == -	F 431	A. (	n 10-17-11	the fact	Llity
	COLLEGIES SILICE IS	maintained and periodically		disposed	of the exp	ired	
	reconciled.	and periodically		acetamir	ophen suppo	sitories	3
	Datas and blut-ut			Finnediat	ely. Replac	ement	
ì	labeled in accordan	als used in the facility must be ce with currently accepted		on 10-17	cories were -11 and exp	ordered	
	professional princip	les and include the		date was	reviewed.	Tration	
1	APPLUDITION SUCCESSI	Try and condings		consulta	int pharmaci	tue	9
	moducions, and the	expiration date when		was noti	fied by	DOM	3
	applicable.			of this	finding on	10-20-11	
ĺ	in accordance with s	State and Federal laws, the		day.			ь
10	ALMINA HITEST SIGNE SIL	OF ICC ORD BIAL		B. N	o adverse o	utcomes	
	CONTRACTOR CONTRACTOR	E linder provents		were fou	nd related	to	
	with mind DCIMIL	Univ Suitorized parent	-	expirati	on of aceta	minophen	L
1	have access to the k	eys.		supposit	ories. The	nursing	
	The facility must		1	stail wa	s inservice	d by .	
		vide separately looked, compartments for storage of	i	, DON	on 11-1-20	11 &	
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1 -		HOD EVERAND IN HILL I	1	C. N	ursing staff	F War	- 1
6	e readily detected.	imal and a missing dose can		inservice	ed by	DON	İ
	y TVIDOLEG.			on 11-1-2	2011 through	11-3-1	1
!		8		through s	sharing of s	urvey	
7.	in DECLUDENCE			results a	and the plan	of	
by	IIS REQUIREMENT	is not met as evidenced		correctio	on to checki	ng før	
B	Ased on observation	and interest on a second	i	expired d	irugs.		
fai	iled to ensure stock	and interview, the facility medications assigned for		D 0			
110	하고 다 내 다 있는 사람(중 LUSI)	Mainer within the		D. Qu	ality assur	ance	1
100	anuracturer's expirat	ion date in one of two		writandif	every 3 mo	nths	1
me	edication rooms.	71 1370		and the	RN for comp	Tiance	.
1	o findings := t + t + t			will moni	consultant p	narmacis	;t
1,11	e findings included:	, I	1	for compl	iance of me	dientier	
CMS-2567/03	2-99) Previous Versions Obso	Jan		expiratio	n dates for	arcation	.
	/ revidus versions Obsc	plete Event ID: JIEC11	Facility	ID: TN4718		accurac	. Y

CENTE	ERS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	D: 11/08/201 MAPPROVE
S IV I EWEL	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445415	(X2) MULT A. BUILDII B. WING		(X3) DATE COMPL	). 0938-039 SURVEY
NAME OF	PROVIDER OR SUPPLIER	.1			10/	21/2011
	ALTHCARE, FARRA		1 7	REET ADDRESS, CITY, STATE, ZIP COD 120 CAVETT HILL LANE KNOXVILLE, TN 37822	E	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S GROSS-REFERENCED TO THE AR DEFICIENCY)	WOIDE	(X5) COMPLETION DATE
	Observation with the 17, 2011, at 10:00 medication room in milligram, acetamin designated as stock were out of date. Of the expiration date was March 2011.  Interview with the C 2011, at 10:00 a.m., room confirmed the	e Charge Nurse on October a.m., in the first floor evealed thirty-five, 650 ophen suppositories a medications for resident use ontinued observation revealed on the suppository package tharge Nurse on October 17, in the first floor medication	F 431		1 F-431	
SS=D	SPREAD, LINENS  The facility must estinfection Control Prosented to Series and the Series and th	ablish and maintain an gram designed to provide a emfortable environment and evelopment and transmission ion.	F 441	*		11/11/11
P   (1   in   (2   si   (3	ne facility must esta Program under which () Investigates, conta the facility; (2) Decides what produced to a	blish an infection Control it - rols, and prevents infections redures, such as Isolation, in individual resident; and				
de pre isc	event the spread of t plate the resident.	of Infection Control Program dent needs isolation to nfection, the facility must ohibit employees with a				

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES					
_CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				FORM	11/08/201 APPROVE
1 STATEME	NT DE DEELCJENSIES	CYD BEOMOS DISTRIBUTION				OMB NO	0. 0938-036
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M(	(X2) MULTIPLE CONSTRUCTION			URVEY
			A. BUIL	DING		COMPL	ETED
3		/45445	B. WING				
NAME OF	NAME OF PROVIDER OR SUPPLIER		0, 14114	•		10/5	21/2011
				STREET ADDRESS, GI	ITY, STATE, ZIP CODE	1012	112011
NHCHE	EALTHCARE, FARRAG	UT		120 CAVETT HILL	LANE		
		100 - 100 -		KNOXVILLE, TN			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVID	ER'S PLAN OF CORDER	277033	
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	PREFIX	I CERCH GO	RRECTIVE ACTION ONE	MILTON	COMPLETION
			IAG	CROSS-REF	ERENCED TO THE APPE DEFICIENCY)	ROPRIATE	DATE
	Francisco de Re						
F 441	itiniana i tom pai	ge 12	F 44	1 A. R	10 to a filt had		
	communicable disea	ase or infected skin lesions	'7		esident #9	oxygen	S
	from direct contact v	With residents or their fond is	1	bumidif:	asal cannul	a and	
	I direct contact will the	ansmit the disease		immodiat	cation bott	Le was	
	(3) The facility must	require staff to wash their		10-18-11	ely replace		_
	hand washing is indi	eot resident contact for which		labolod	ρλ	.RN and	d
*	professional practice	caled by accepted	.	Aerosol	according t	O NHC.	s .
	practice	•		and reed	policy.LPN ucated to c	was in	cormed
	(c) Linens			medicati	on procedur	orrect:	
	Personnel must handle, store, process and		Į.	infectio	n control g	e and	
8	mensport intells 20 St	s to prevent the spread of	1	at time	of occurren	urderit	ies
	Infection.				, RN-CC	ice by	
ļ				again on	10-21-11 b	and j	
			]	DON-	10 Z1-11 D	Y	,
	This REQUIREMENT	is not met as evidenced	1			1	
1	Ly.			B. T	hese two oc	Current	700
İ	Based on observation	n, review of facility policy,		were rep	orted to th	0	es
	and interview, the fac	ulty tailed to follow the -ti-		Infection	n Control T	eam on	
1	control galdelines tor	THE USE OF OWNER		10-24-11	. The nursi	ng staf	f l
}	edaily userif to to the	sident (#9) of forty residents		was inse	rviced by		DON
	a sanitary menner for	to administer medications in		on 11-1-	2011 & 11-3	-2011 (	
	residents observed for	r one resident (#539) of ten r medication administration.		regarding	g aerosol po	olicy	ind
- 1				infection	a control a	uidel.∜n	es
1.	The findings included:			related t	to medication	on	- 1
1		1		administ	ration. No	adverse	
1	Resident # 9 was read	mitted to the facility on		outcomes	were found	relate	d b
	september 21, 2011.	MID diagnoses including		to oxyger	n tubing and	d infeć	tion
F	Revision of Left Total	Hip Arthroplasty, status post		control v	violation di	uring	1
F	Ibrillation, Coumadia	Hip Arthroplasty, Atrial Therapy, and Sick Sinus	1	medicatio	on administr	ration.	
5	Syndrome with Perma	nent Pacemaker		ine nurs	ing staff wa	as also	
- 1		9		Inservice	ed on 11-1-1		
10	bservation on Octobe	er 18, 2011, at 10:30 a.m.,		11-3-11 k		RN,	
1 11	incresidents foom.	revealed an oxygen		Intection	Control Ni	ırse	_
C	oncentrator. The hurt	nidity bottle was dated		regarding	infection	contro	1
9'	1/25/11.' The nasal ca	innula tubing was coiled		practices	•	i	
E			- 1			31	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/08/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445415 NAME OF PROVIDER OR SUPPLIER 10/21/2011 STREET ADDRESS, CITY, STAYE, ZIP CODE NHC HEALTHCARE, FARRAGUT 120 CAVETT HILL LANE KNOXVILLE, TN 37922 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREPIX (X5) COMPLETION TAG TAG DATE DEFICIENCY F 441 Continued From page 13 F 441 Nursing staff was around the top of the concentrator and was not inserviced by covered or labeled with a date it was changed. on 11-1-2011 & 11-3-11 through sharing of survey Review of facility policy "Respiratory Services Program-Oxygen delivered by Nasal Cannula". results and the plan of revealed "...Infection Control: 1. Change tubing correction regarding aerdsol and cannula every 7 days. Label each tubing with policy, infection control date, time and your initials. 3. Change humidifier guidelines and medication when empty or at least weekly..." administration guidelines. Interview with the resident on October 18, 2011, Quality assurance | will D. at 10:30 a.m., in the resident's room, revealed ".... audit and monitor compliance use the portable and that machine. I've used that with aerosol policy every (the concentrator) a couple of times in the past 3 months X 2 and PRN. The two weeks..." DON/ADON/ or designated Interview with Registered Nurse (RN) #1 on appointee will monitor October 20, 2011, at 10:15 a.m., in the resident's medication administration room, confirmed the oxygen concentrator and compliance with infection humldifier and tubing had not been changed control practices every according to infection control policy. months X 2 and PRN. The consultant pharmacist will monitor compliance monthly Observation on October 17, 2011, at 9:00 a.m., X 3 then biannually during revealed Licensed Practical Nurse (LPN) #1 prepared medications for resident #539, medication pass observation Continued observation revealed LPN #1 dropped to comply with F-441 one tablet of Metoprolol 50 mg (milligram) and guidelines. one tablet of Spironolactone 25 mg onto the unclean medication cart, picked up each pill with the bare fingers, and placed them into the medication cup. Continued observation revealed LPN #1 continued to add the other clean medications to the unclean medications in the medication cup. Continued observation revealed LPN #1 administered the unclean medications to resident #539.